

United States District Court,  
Western District of Washington  
at Seattle

FILED  
LODGED

ENTERED  
RECEIVED

16 CV-00377 JCC

Lance P. McDermott  
Plaintiff, *Pro Se*,

Case No.:

AT SEATTLE  
CLERK U.S. DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON  
DEPUTY

vs.

) Motion for Injunctive relief

U.S. Postal Service (USPS),  
Postmaster General, Megan Brennan, *Et Al*; Noted for Consideration on

) 1 April 2016

and  
Greater Seattle Area Local (GSAL),  
American Postal Workers Union  
(APWU), AFL-CIO, President, Myrna  
Umali; *Et Al*, Salaried Union Officials.

Defendants.

I filed a request for back pay, 12 January 2015 (enclosed), I have not received the back-pay or a denial and appeal rights. I plead for the preliminary injunctive relief of the immediate restoration of over 9-months back-pay and of over 900 hours of sick and annual leave wrongfully taken.

I have (1) a strong likelihood of success on the merits of my discrimination complaints, (2) I will suffer irreparable injury, - bankruptcy, - no sick leave, and unable to afford an attorney, (3) it will harm others if I do not – wife/creditors, and (4) the public interest will be furthered by showing that willful discrimination will not be tolerated.

1 Agency Handbook PO-702, Tort Claims Administration .431.2, - "When a valid  
2 claim is received and it appears the Postal Service liability can be clearly  
3 established, a fair and reasonable settlement should be offered."

4  
5 The Civil Service Reform Act, Back Pay Act of 1966 (5 U.S.C. § 5596), - "...an  
6 amount equal to all or any part of the pay, ... which the employee normally would  
7 have earned or received during the period of the personnel action had not  
8 occurred..." The Back Pay Act requires back pay to employees subjected to  
9 unjustified or unwarranted personnel action which has resulted in the withdrawal  
10 or reduction of all or part of the [employee's] pay. 5 U.S.C. §§ 5596(b)(1),  
11 (b)(1)(A)(i), (b)(2)(A). 5 C.F.R. § 550.804(b)(1). Defining an "appropriate  
12 authority" as "an entity having authority in the case at hand to correct or direct the  
13 correction of an unjustified or unwarranted personnel action, including ... a  
14 court." 5 C.F.R. § 550.803. See *DAVID P. ADAM; et al (class), v. U.S.*  
15 *Department of the Interior*, Case: 09-17091 03/01/2011, ID: 7663304, DktEntry:  
16 17-1(9<sup>th</sup> Cir. 2011).

17  
18  
19  
20  
21 Section 501 of the Rehabilitation Act prohibits discrimination and OPM  
22 Regulation 353.304© states that discriminated employees "must be restored to all  
23 rights and benefits" if the disability was the "motivating factor" behind the  
24 discrimination, 29 U.S.C. § 791(g).  
25

1 In *Heck v. Humphrey*, 512 U.S. 477, 114 S.Ct. 2364 (1994), the Supreme Court  
 2 stated, - "In order to recover damages for allegedly unconstitutional conviction or  
 3 imprisonment, or for other harm caused by actions whose unlawfulness would  
 4 render a conviction or sentence invalid. A [§ 1983] plaintiff must prove that the  
 5 conviction or sentence has been reversed on direct appeal, expunged by executive  
 6 order, declared invalid... 28 U.S.C. § 2254. 512 U.S. at 486-87. My unjust  
 7 enforced leave overturn, - RTW approval, MM Norris, 6 Mar 14 (exhibit K10),  
 8 and PS Form 50, 11 March 2014 (exhibit V).


11 USPS Management Instruction, EL-430-2012-4, Back Pay, Authorization - "A  
 12 rescission, i.e., a unilateral cancellation of modification of a personnel action by  
 13 the Postal Service." Indefinite Suspension, - "Back pay period of more than 6  
 14 months - the employee must provide documentation detailing his..." Manager of  
 15 Employees Submitting Back Pay Claims, - "Is responsible for..." "Providing the  
 16 claimant with the necessary forms and instructions..."

19 The Supreme Court found that, despite reinstatement and back-pay the  
 20 employee and their family still "had to live for 37 days without income [and  
 21 without knowing] whether or when the employee could return to work.... an  
 22 indefinite suspension without pay could well act as a deterrent, even if the  
 23 suspended employee eventually received back pay." *Burlington Northern Santa*  
 24 *Fe Ry. Co. v. White*, 126 S.Ct. 2405, 2410-16 (2006), 548 U.S. at 67 and 73.  
 25 "Emotional trauma ... suffered as a result of an [allegedly] hostile work

1 environment" can constitute injury that is sufficient to establish Article III  
2 standing. *Leibovitz v. New York City Transit Auth.*, 252 F.3d 179, 185 (2dCir.  
3 2001).

4 The original decision to place me on unpaid enforced leave, because of my  
5 disability, has been over-turned. Therefore, I request immediate restoration of my  
6 back pay and the over 900-hours of saved sick and annual leave that was  
7 wrongfully taken from me.  
8

9 Respectfully submitted this 14<sup>th</sup> of March 2016,  
10

11   
12 Lance McDermott  
13 1819 So 104 ST  
14 Seattle, WA 98168  
15 206 331-1990  
16 treke@hotmail.com  
17  
18  
19  
20  
21  
22  
23  
24  
25

12 January 2015

Request for Back-Pay

I request Back Pay pursuant to EL-430-2012 rescission of the Enforced Leave personnel action by the Postal Service.

I request that my Back-Pay packet forms PS 8039, PS 2146, PS 8038, PS 2240, and PS 8041 be processed.

I request that my 926 hours of sick and annual leave used be restored.

I request to be paid back the \$794.10 paid for Health Care Benefits.

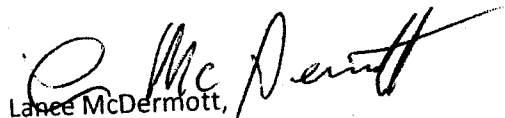
I request to be paid back the \$1,047.09 I had to pay TSP.

I request to be paid back the 64 hours of annual leave withheld in 2014.

And, I request that interest be paid.

Please process my Back-pay within the required 30 days of submission or let me know of any missing documents before denial.

Thank you,

  
Lance McDermott,  
1819 So 104 ST  
Seattle, WA 98168  
206 331-1990

*Supervisor*

*Ann: Ruf 1/14/15*



# Back Pay Decision/ Settlement Worksheet

**Instructions:** This form is used to submit a claim for payment of back pay compensation authorized by (1) a settlement agreement, arbitration award, or agency or court decision in the case of a contested personnel action; (2) a rescission by management in the case of an uncontested personnel action; or (3) a Postal Service™ approval of back pay in case of an erroneous retirement determination.

The claimant, the Postal Service certifying officials, and the Postal Service final approval authority must all sign this form to acknowledge that they have reviewed its contents and agree with the statements made on this form. A form missing any of the three signatures will be returned to the originating office.

## A. Claimant Identification

Claimant Name (Last, First, MI) <i>McDermott, Lance P</i>		Employing Office Address (Number, street, suite, etc.) <i>22430 Russell Road, Bldg "C"</i>	
Designation/Activity Code (DES/ACT) <i>16/8</i>	Claimant EIN (Employee ID) <i>03272132</i>		
USPS® Contact Name (Last, First, MI) <i>Alexis Delgado</i>		City <i>Kent</i>	State <i>WA</i>
USPS Contact Office Address (Number, street, suite, etc.) <i>34301-9th Ave. S, Ste. 215</i>		ZIP+4® <i>98032</i>	
Employing Office Telephone Number (including area code and extension) <i>206-437-2198</i>			
City <i>Federal Way</i>	State <i>WA</i>	ZIP+4 <i>98003</i>	USPS Contact Telephone Number (including area code and extension) <i>206-381-6692</i>

## B. Claim Information

Back Pay Period: From (MM/DD/YYYY) <i>05/30/2013</i>	Back Pay Period: To (MM/DD/YYYY) <i>03/14/2014</i>	Finance Number to Be Charged <i>54-7649</i>	Date of Settlement, Decision, Ruling or Erroneous Retirement Determination (MM/DD/YYYY) <i>03/11/2014</i>
Does this settlement or decision constitute, or include, a lump sum payment? (If yes, please state amount and relevant pay period (PP/YY).) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes \$ _____		Did this settlement or decision award court costs or attorneys' fees? If yes, please provide the amount, payee(s) names, mailing addresses, and tax identification number(s) (TIN). <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Relevant Pay Period _____ / _____		NOTE: Attach additional information as necessary.	
Claim Category <input checked="" type="checkbox"/> Contested Personnel Action <input type="checkbox"/> Settlement <input checked="" type="checkbox"/> Decision <input type="checkbox"/> Rescission <input type="checkbox"/> Erroneous Retirement Determination Approved for Back Pay <input type="checkbox"/> Other (specify): _____	Employee Status During Back Pay Period <input checked="" type="checkbox"/> LWOP <input type="checkbox"/> Separated <input type="checkbox"/> Denied Employment <input type="checkbox"/> Duty Status Unchanged <input type="checkbox"/> Separated Erroneously for Retirement <input checked="" type="checkbox"/> Other (specify): <i>Enforced Leave</i>	Forum for Settlement or Decision <input type="checkbox"/> Pre-arbitration <input type="checkbox"/> Pre-trial <input type="checkbox"/> Equal Employment Opportunity Commission (EEOC) <input type="checkbox"/> Merit Systems Protection Board (MSPB) <input type="checkbox"/> Arbitration Decision <input type="checkbox"/> Court Decision <input checked="" type="checkbox"/> Other (specify): <i>See Exhibit 3</i>	

## C. Interest and Reimbursable Expenses

Is interest expressly awarded in the settlement?

☒ No  
☐ Yes

NOTE: Interest is computed after the claim has been processed and is paid by a separate check.

Is any portion of this claim for compensatory damages? (If yes, please state amount.)

☒ No  
☐ Yes \$ \_\_\_\_\_

Is any portion of this claim for reimbursable expenses (such as per diem and/or mileage)? (If yes, please state amount.)

☒ No  
☐ Yes \$ \_\_\_\_\_

NOTE: Expenses must be substantiated by expense report.

**D. Compensation from the Postal Service and Other Sources**

- (1) Is the claimant a former Postal Service employee who received a terminal payout for accrued annual leave upon separation? (If yes, please enter the gross dollar amount and date paid.)

☒ No

☐ Yes Amount (Gross) \$ \_\_\_\_\_

Date Paid (MM/DD/YYYY) \_\_\_\_\_

- (2) Is the claimant a former Postal Service employee who was overdrawn for annual leave upon separation and therefore had an invoice (Notice of Demand) issued? (If yes, please enter the gross dollar amount.)

☒ No

☐ Yes Amount (Gross) \$ \_\_\_\_\_

- (3) Did the claimant receive workers' compensation during the back pay period? (If yes, list date(s) verified by the U.S. Department of Labor in the columns below.)

☒ No

☐ Yes

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Gross Amount Received \$

NOTE: Attach additional information if necessary.

- (4) Did the claimant receive unemployment benefits during the back pay period? (If yes, list date(s) verified by state employment security agencies in the columns below.)

☐ No

☒ Yes

If yes, which state(s)? Washington

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Gross Amount Received \$
<u>09/20/2013</u>	<u>09/11/2014</u>	<u>\$15,704</u>

NOTE: Attach additional information if necessary.

- (5a) Did the claimant obtain outside employment during the back pay period? (If yes, list date(s) in the columns below.)

☒ No

☐ Yes

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Gross Amount Received \$

NOTE: Outside employment is employment the employee obtained during the back pay period.

- (5b) If the answer to outside employment is no, was the claimant ready, willing, and able to work?

☐ No

☒ Yes

NOTE: If the claimant was ready, willing, and able to work but failed to seek outside employment, the claimant will be denied back pay compensation, subject to the provisions of the Employee and Labor Relations Manual (ELM) 436.2, limitations. Please list any period(s) of time to be disallowed from the back pay award in Section F below.

- (6a) Was the claimant self-employed during the back pay period?

☒ No

☐ Yes

- (6b) If yes, report the difference between what was earned in the 6-month period prior to the back pay period and what was earned during the back pay period.

\$ \_\_\_\_\_ (Gross)

NOTE: For more information, see IRS Publications 334, Tax Guide for Small Businesses, and 535, Business Expenses.

- (7a) Did the claimant have secondary employment during the back pay period?

☒ No

☐ Yes

NOTE: Secondary employment is employment that the claimant had while working for the Postal Service directly prior to the back pay period and that would have continued even if the claimant had remained working for the Postal Service.

- (7b) If yes, did work hours of secondary employment increase during the back pay period?

☐ No

☐ Yes

If yes, report any increase between what was earned in the 6 months prior to the back pay period and during the back pay period.

Gross Increase Amount \$ \_\_\_\_\_



**E. Benefit Elections****Health Insurance**

- ☐ No Coverage
- ☒ Enrollment Continued (Never Terminated) *\* See Exhibit 4*
- ☐ Retroactive Reinstatement
- ☐ Enroll as a New Employee

Plan Code: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**Thrift Savings Plan** *\* See Exhibit 4*

- ☐ No Participation
- ☐ Retroactive Reinstatement

Contribution Rate (%) \_\_\_\_\_

Or \$ \_\_\_\_\_ per pay period

Effective Date: \_\_\_\_\_

**NOTE:** Attach copies of the TSP Election form(s) covering the back pay period. Upon returning to work, the claimant must access *PostalEase* if the claimant wishes to participate in TSP and have contributions deducted from current earnings.

**Retirement Benefits**

(1a) Did the claimant receive any annuity payments from the federal government during the back pay period?

☒ No☐ Yes

If yes, please enter the claimant's Civil Service Annuity (CSA) retirement account number \_\_\_\_\_ and report the amount(s) received.

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Gross Amount Received \$

**NOTE:** Attach additional information if necessary.

**NOTE:** The above amount(s) will be deducted automatically from the back pay award and electronically transmitted to the Office of Personnel Management (OPM) to satisfy the claimant's indebtedness and restore applicable retirement credit.

**Flexible Spending Accounts**

- ☐ Claimant was not participating in FSA prior to back pay award.
- ☐ Claimant was participating in FSA, but chose Option #1 on PS Form 8038 not to have participation restored for remainder of Plan year. (Claimant will be invoiced for any FSA contribution arrearage up to eight pay periods.)
- ☒ Claimant chose Option #2 on PS Form 8038 to have FSA participation restored up to the balance of the Plan year. (Claimant will owe additional FSA contributions for the additional term of participation.)
- ☐ Claimant missed FSA Open Season during the back pay period and has been advised to contact the Human Resource Shared Services Center if New Enrollment (as Belated Enrollment) is desired.

**Leave Benefits**

- ☐ No Leave Benefits
- ☒ Full Leave Benefits
- ☐ Partial Leave Benefits
- If "partial leave benefits" is checked, please explain below:

**NOTE:** Unless specifically addressed in the settlement or decision, claimants who receive a lump sum payment typically do not have leave benefits credited for the back pay period. Alternatively, unless stated otherwise in the settlement or decision, claimants who receive other than lump sum disbursements are typically credited with full leave benefits up to the maximum allowable carry-over, as would have accrued if they had been active employees in pay status during the back pay period.

(1b) Did the claimant make a voluntary withdrawal of retirement funds, either CSRS or FERS?

☒ No☐ Yes Amount \$ \_\_\_\_\_

**NOTE:** The above amount(s) will be deducted automatically from the back pay award and electronically transmitted to the Office of Personnel Management (OPM) to satisfy the claimant's indebtedness and restore applicable retirement credit.

**Life Insurance**

Eligibility for life insurance coverage after a return to pay and duty status is determined by the law and regulations for the Federal Employees Group Life Insurance (FEGLI) Program, administered by the Office of Personnel Management (OPM). For detailed information on how FEGLI handles coverage in such situations, and what options are available to a Postal Service employee, see ELM 436.5, Life Insurance Coverage.

**F. Periods Disallowed**

For Failure to Seek Outside Employment (List dates below.)


Claimant Unable to Perform Postal Service Job and Did Not Elect to Substitute Annual or Sick Leave, per ELM 510 (List dates below.)


**G. Salary Progression**

If award is to make the employee whole, all salary history corrections must be made before submission of back pay documents to the Eagan ASC for processing (e.g., step deferments for LWOP during back pay period should be canceled). A copy of the revised service history is acceptable.



**H. Work Schedule**

Please complete the following information:

Tour start time: 0500Tour end time: 1330

Lunch period: \_\_\_\_\_

Rural Carriers — Evaluated Weekly Hours: \_\_\_\_\_

**Nonscheduled Days**

- ☒ Saturday  
☐ Sunday  
☐ Monday  
☐ Tuesday  
☐ Wednesday  
☐ Thursday  
☒ Friday

**Scheduled Days**

- ☐ Saturday  
☒ Sunday  
☒ Monday  
☒ Tuesday  
☒ Wednesday  
☒ Thursday  
☐ Friday

**Instructions:** In the sheet below, enter the paid hours that would have occurred during the back pay period had the claimant worked. For employees with flexible work schedules, complete all the applicable columns for the 13 pay periods prior to removal, separation, or extended LWOP, per ELM 436. If the claimant did not work 13 pay periods prior to removal, separation, or extended LWOP, list as many pay periods as are available.

Year	PP	Week	Work Hours (52)	Overtime (53)	Night Shift Differential (54)	Holiday Work (57)	Holiday Leave (58)	Sunday Premium (72)	Annual Leave (55)	Sick Leave (56)	Other (Please specify)
2013	30 May 13	1	40		5			8			
		2	40		5			8			
2013	14	1	40		5			8			
		2	40		5		8	8			
2013	15	1	32		4		8	8			
		2	40		5			8			
2013	16	1	40		5			8			
		2	40		5			8			
2013	17	1	40		5			8			
		2	40		5			8			
2013	18	1	40		5			8			
		2	40		5			8			
2013	19	1	40		5			8			
		2	32		4		8	8			
2013	20	1	40		5			8			
		2	40		5			8			
2013	21	1	40		5			8			
		2	40		5			8			
2013	22	1	40		5			8			
		2	32		4		8	8			
2013	23	1	40		5			8			
		2	40		5			8			
2013	24	1	40		5			8			
		2	32		4		8	8			
2013	25	1	40		5			8			
		2	32		4		8	8			



**I. Special Instructions**

Please list any special instructions: (e.g., mailing instructions or joint name on payments).

NOTE: Back pay awards are typically paid via a paper check mailed to the address of record for the finance number expensed. Alternative mailing arrangements are not available unless a settlement or decision specifically directs other mailing procedures, or the payment is for interest, non-wage income, or reimbursable expenses.

**J. Signatures**

Claimant's Name (please print)

*Lance McDermott*

Signature

*[Signature]*

Date (MM/DD/YYYY)

*06/05/2014*

Certifying Official's Name and Title (please print)

Signature

Certifying Official's Mailing Address (Number, street, suite, etc, if different from USPS contact address on page 1)

City

State

ZIP+4®

Certifying Official's Telephone Number (including area code and extension)

Final Approving Authority Name and Title (please print)

Signature

Date (MM/DD/YYYY)

**K. Privacy Act Statement**

Your information will be used to process your back pay claim. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004, 1005, and 1026; and 29 U.S.C. 2601 *et seq.* Providing this information is voluntary, but if not provided, we may not process your back pay claim.

We may only disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local, or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; and to federal, state, or local governments administering benefit or other programs to conduct a computer match to verify eligibility, indebtedness, or compliance with requirements of the program.

**L. Mailing Instructions**

If this claim is (1) a pre-arbitration, agency, or pre-trial settlement with less than one pay period of hours adjustments (i.e., less than 80 hours), or (2) an agency, court, or arbitration decision with a lump sum payment of less than \$10,000 or with less than one pay period of hours adjustments:

Mail to: Accounting Services  
Payroll Services – Pay Location 9631  
2825 Lone Oak Parkway  
Eagan MN 55121-9631

Otherwise mail to: Accounting Services  
Financial Processing – Pay Location 9616  
2825 Lone Oak Parkway  
Eagan MN 55121-9616

## Attachment D

## Back Pay Documentation Requirements (page 1 of 2)

## Terms:

**Decision** — a document that memorializes an official determination made by a third party (such as a federal judge, administrative law judge, arbitrator, or hearing officer) regarding the appropriateness of a personnel action.

**Settlement** — a document that memorializes an agreement between an individual or his or her representative and the U.S. Postal Service.

**Rescission** — a unilateral ruling by management that an employee is to be paid for time not worked or time worked at a lesser number of hours or lower pay level.

**Erroneous separation for retirement** — approval of back pay when OPM officially denies a retirement application because of the employee's failure to fulfill eligibility criteria. Back pay for erroneous separation for retirement requires approval by the Manager, Retirement Programs, HQ Compensation, prior to processing.

Authority by Which Award Was Granted	Lump Sums Awards and Documents Required									
	Less than \$10,000.00					\$10,000.00 to \$99,999.99				
	PS Form				Copy of Award	Mailing Address	PS Form			
	GATS	2240	8039	8041			GATS	8039	8041	PS Form
Grievance-Arbitration <sup>1</sup>	X	X			X		X			X
EEOC, MSPB, OPM, Other <sup>2</sup>			X	X	X	B		X	X	X
Rescission		X			X	A			X	X

8038 Statement  
2146 Claim

closed

<sup>1</sup> Lump sum grievance and pre-arbitration settlements and arbitration awards less than \$100,000 must be processed via GATS. If payment cannot be made via GATS, and is less than \$10,000, submit PS Form 2240 to Address A below. If between \$10,000 and \$99,999, send PS Form 8041 to Address B. A lump sum back pay award of \$100,000 or more must be submitted on PS Form 8039 to Address C.

<sup>2</sup> Third party or agency settlements may be submitted on PS Form 8041 if under \$100,000. Third party or agency decisions always require PS Form 8039 in lieu of PS Form 8041, regardless of amount.

## Mailing Addresses

- A. USPS SCANNING & IMAGING CENTER  
PO BOX 5212  
JANESVILLE WI 53547-5212
- B. ACCOUNTING SERVICES  
PAYROLL SERVICES – PAY LOCATION 9631  
2825 LONE OAK PARKWAY  
EAGAN MN 55121-9631
- C. ACCOUNTING SERVICES  
FINANCIAL PROCESSING – PAY LOCATION 9616  
2825 LONE OAK PWY  
EAGAN MN 55121-9616



# EMPLOYEE'S CLAIM FOR PERSONAL PROPERTY

Type or write legibly in ink. Submit in triplicate to your supervisor within 14 days (if you are a bargaining employee), or 90 days (if you are a non-bargaining employee) from the date that loss or damage occurred.

## Part One - This Page Completed by Employee

Name of Claimant <b>Lance McDermott</b>	SSN <b>538-66-9927</b>	Job Title of Claimant <b>MPE/09</b>
Claimant's Home Address <b>1819 S. 104th St. Seattle, WA 98168</b>	Claimant's Work Address/Work Phone Number <b>22430 Russell Road, Bldg "C" Kent, WA 98032</b>	
Date Loss/Damage Occurred <b>30 May 2013</b>	Total Amount of Claim <b>\$ 72,167</b>	
Article(s) for Which Claim is Made  (Include paid receipt or other evidence showing purchase date and original price of lost or damaged article. If repairable, include an estimate for repair. If not repairable include a statement from a tailor, dry cleaner, etc., to substantiate. If claim is for eyeglasses, state exactly what part(s) are broken. Include an itemized receipt for the REPLACEMENT of damaged part(s). Replacement must be of the same quality as the damaged part(s).)  <b>Back Pay FMLA Leave - See Exhibit 7 PS Form 2485 5. Eyes - e. Is color vision normal... <del>ANC</del> 4. Risk Assessment - Essential Functions + EOPF Exhibit 8</b>		
Description of Loss or Damage (Give place, extent of damage, and circumstances of accident involving loss or damage. State salvage value.) <b>From 30 May 2013 to 11 March 2014 Essential job functions - See PS Form 2485 Dated 24 Oct 1996</b>		
Insurance Coverage/Recovery Attempt		
Homeowners Insurance <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Collision <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Comprehensive <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Other (Specify):  Has Claim been Filed with Insurance Company? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "yes", action taken:	Name & Address of Insurance Company  Amount of Deductible \$ If damage/loss result from the negligence of another party, has an attempt been made to recover from that party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If "Yes" explain on separate sheet.)	
I certify that the damage, loss, or destruction was not caused in whole or in part by any negligence or wrongful act of the claimant, or his agent or employee. All articles listed on this sheet (or additional sheets made part of this form) have been privately purchased and are not government property. No previous claim has been made to the government for the property for which this claim is made (except as explained on the attached sheet). This claim does not duplicate any made under the Workman's Compensation Program.  If any of the property for which claim is made is later recovered, claimant agrees to give written notice immediately to the US Postal Service.		
I make the foregoing claim with full knowledge of the penalties involved for willfully making a false claim. (US Code, Title 18, Section 287, provides for a maximum fine of \$10,000 or imprisonment for 5 years, or both.)  I hereby assign to the United States to the extent of any payment of this claim accepted by me all my right, title, and interest in and to any claim that I may have against any insurer or other party, arising out of the damage, loss, or destruction to the property described on this form and will, upon request, furnish such evidence as may be required to enable the United States to enforce such claim.		
PRIVACY ACT: The collection of this information is authorized by 39 USC 1001 & 2008. It will be used to reimburse you for a loss of personal property. As a routine use, this information may be disclosed to an appropriate law enforcement agency for investigative or prosecutorial purposes, to a congressional office at your request, to OMB for review of private and relief legislation, to a labor organization as required by the NLRA, to the Office of EEOC when investigating an EEO complaint and where pertinent, in a legal proceeding to which the Postal Service is a party. Completion of this form is voluntary, however, if this information is not provided, it will result in your not receiving reimbursement for a personal loss.		
Date of Claim <b>9 June 2014</b>	Claimant's Signature 	

## Part 2 - Completed by Union Steward (Bargaining Employees)

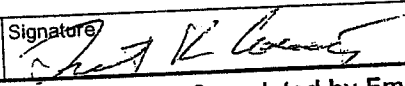
Recommendation

PAY Employee A 11 BACK PAY FOR 9 months 701 hrs  
 due to being placed on enforced leave by management  
 IT MANAGEMENT'S decision in amount of \$72,500.00

Date of Recommendation

6/5/14

Signature



Name of Union

APWU

## Part 3 - Completed by Employee's Supervisor

(Forward non-bargaining unit claims immediately to: General Manager, Field Division (for Field Units); Regional Director, Human Resources (for Regional Office Units); and General Manager, Headquarters Personnel Division (for Headquarters and Related Units). Forward bargaining unit claims immediately to: Regional Labor Relations Office.

1. Was Claim Submission Timely? ☐ Yes ☐ No (If "no", explain.)

Is Part 1 Complete? ☐ Yes ☐ No

Is Part 2 Complete? ☐ Yes ☐ No

2. Was possession of lost/damaged property reasonable, proper, and necessary to the performance of the employee's employment?

☐ Yes ☐ No (If "no", explain.)

3. Was there any negligence on the part of the employee which contributed to the loss/damage?

☐ Yes ☐ No (If "no", explain.)

4. Supervisor's Review (State facts related to claim developed through your investigations, e.g., caused by faulty equipment. Provide basis for recommendation of payment or denial.

5. Based on the above, do you recommend payment?

☐ Yes ☐ No

Date of Report

Finance No. of Postal Installation

Signature and Title of Supervisor





# Employee Statement To Recover Back Pay

**INSTRUCTIONS:** An employee may receive payment of back pay compensation authorized by: (1) a settlement agreement, arbitration award, or agency or court decision in the case of a contested personnel action; (2) a rescission in the case of an uncontested personnel action; or (3) a United States Postal Service® approval of back pay in the case of an erroneous retirement determination.

If you have been authorized to receive back pay compensation by one of the methods shown above, before your back pay claim can be processed, you must:

- Complete this form.
- Provide all required supporting documentation. Attach additional pages as necessary, noting on each attached page the question to which it relates.

## A. Employee Identification

Name (Last, First, MI)

McDermott, Lance P

Address (Number, street, box, ste./apt. no.)

1819 S. 104th St.

Claimant's EIN (Employee ID)

03272132

City

Seattle

State

WA

ZIP+4®

98168

Telephone No. (Include area code)

206-763-6268

Current Position Title

MPE/09

Designation/Activity Code (DES/ACT)

16/8

Back Pay Period: From (MM/DD/YYYY)

05/30/2013

Back Pay Period: To (MM/DD/YYYY)

03/14/2014

Employing Office Finance No.

54-7649

Employing Office Telephone No. (Include area code)

253-437-2198

Employing Office Address (Number, street, box, ste./apt. no.)

22430 Russell Road, Bldg "C"

City

Kent

State

WA

ZIP+4

98032

USPS® Labor Relations or Human Resources Contact

Alexis Delgado

USPS Contact Telephone No. (Include area code)

206-381-6692

## B. Statement Questions

### Employment – Questions 1 – 4

- Did you seek outside employment during the back pay period?

☒ Yes ☐ No

**NOTE:** Outside employment is employment you obtained during the back pay period.

**NOTE:** Postal Service™ employees eligible for veterans' preference are not required to make reasonable efforts to obtain other employment while pursuing an administrative appeal with the Merit Systems Protection Board (MSPB).

→ Desert Storm Veteran, see Exhibit 1

If YES, and if no outside employment was obtained for all or part of the back pay period, you must furnish the information required below based on the type of personnel action and the length of the back pay period.

- SEPARATIONS AND INDEFINITE SUSPENSIONS. If the back pay claim is for a period of separation or indefinite suspension, you must furnish the following:
  - If the back pay period is 45 days or less, you must the answer questions on this form.
  - If the back pay period is more than 45 days but less than 6 months, you must provide a written explanation of the reasons outside employment was not obtained for all parts of the back pay period except for the first 45 days.
  - If the back pay period is 6 months or more, you must provide detailed information concerning the efforts you made to obtain other employment for all parts of the back pay period except for the first 45 days. Please provide the following information for each employer:



Questions 1 - 4 continued

- (a) The date or approximate date the contact was made.
- (b) The business name, address, and telephone number.
- (c) Whether the contact was in person, by telephone, or by mail.
- (d) The name of the person contacted or who conducted the interview.
- (e) Whether an employment application was filed.
- (f) The reason, if known, why employment was not offered.

b. DENIAL OF EMPLOYMENT. If the back pay claim is for a period during which employment with the Postal Service was denied, you must provide the information required in item 1a(3) above for ALL parts of the back pay period during which other employment was not obtained.

2. Did you have earnings from outside employment during the back pay period?

If YES, you must attach a statement from **each** of your employers showing the total number of hours you worked and your gross earnings for the back pay period.

**NOTE:** Outside employment is employment you obtained during the back pay period.

☐ Yes ☒ No

Attach your employment/earnings statement.

3a. Did you have any earnings from secondary employment during the back pay period?

**NOTE:** Secondary employment is employment that you had while working for the Postal Service directly prior to the back pay period and that would have continued even if you had continued working for the Postal Service.

If NO, go to question 4.

If YES, you must attach a statement from **each** of your employers showing the total number of hours you worked and your gross earnings for the back pay period and go to question 3b.

☐ Yes ☒ No

Attach your employment/earnings statement.

3b. Were the work hours of your secondary employment expanded (increased) during this period?

If YES, you must submit a statement from **each** of your employers showing the hours you worked and your gross earnings for the 6-month period prior to the beginning of the back pay period as well as for the back pay period.

Attach your employment/earnings statement.

☐ Yes ☒ No

4. Were you self-employed during the back pay period?

If YES, you must submit an affidavit indicating the gross amount earned and any deductions for ordinary and necessary business expenses incurred in conjunction with such self-employment. Any business expense deductions claimed must be itemized and substantiated by receipts or other documentation, when available. If such employment existed prior to the back pay period, you must also submit your earnings for the 6-month period prior to the beginning of the back pay period.

Attach your affidavit and employment/earnings statement.

☐ Yes ☒ No

**Other Income – Questions 5 – 7a & b****5. Did you receive unemployment compensation during the back pay period?**☒ Yes ☐ No

If YES, identify the state(s) from which unemployment compensation was received, date(s) covered, and amount(s) received, and attach an earnings statement from each state employment security agency.

STATE FROM WHICH COMPENSATION RECEIVED	STARTING DATE	ENDING DATE	GROSS AMOUNT RECEIVED
Washington	9/20/13	3/11/14	\$ 15,704
			\$
			\$
			\$
			\$
			\$

Attach your earnings statements.

**6. Did you receive worker's compensation for any time during the back pay period?**☐ Yes ☒ No

If YES, note whether you received full or partial compensation, identify the date(s) covered and amount(s) received, and attach documentation of the workers' compensation payments received.

FULL OR PARTIAL	STARTING DATE	ENDING DATE	GROSS AMOUNT RECEIVED
			\$
			\$
			\$
			\$
			\$

Attach documentation.

**7a. Did you receive any annuity payments from the federal government during the back pay period?**☐ Yes ☒ No

If YES, write in your Civil Service Annuity (CSA) retirement account number \_\_\_\_\_  
Identify the date(s) covered and amount(s) received.

STARTING DATE	ENDING DATE	GROSS AMOUNT RECEIVED
		\$
		\$
		\$

**NOTE:** The amount will be deducted automatically from the back pay award and transmitted to the Office of Personnel Management (OPM) to be applied to your indebtedness to the federal retirement system and restore the applicable retirement credits.

**7b. Did you make a voluntary withdrawal of deposits made to your CSRS or FERS retirement account?**☐ Yes ☒ No

If YES, please indicate the amount withdrawn \$ \_\_\_\_\_.

**NOTE:** The amount will be deducted automatically from the back pay award and transmitted to the Office of Personnel Management (OPM) to be applied to your indebtedness to the federal retirement system and restore the applicable retirement credits.

Attach additional sheets if necessary.

**Leave – Questions 8a & 8b**

8a. During the back pay period, were you ready, willing, and able to perform your Postal Service job?

☒ Yes ☐ No

If YES, go to question 9.

If NO, provide an explanation of your inability to work and state the beginning date(s) and ending date(s) of each period that you were unable to work, and go to question 8b.

Attach additional sheets if necessary.

8b. Do you want to substitute credited annual leave or sick leave pursuant to the requirements of *Employee and Labor Relations Manual (ELM) 510* for periods when you were not ready, willing, and able to perform your Postal Service job?

☐ Yes ☐ No

**Note:** If you were unable or unwilling to perform your job during the back pay period and you do not request annual or sick leave, you will not receive any compensation from the Postal Service for that period.

If YES, identify date(s) to be covered and type of credited leave to be substituted.

STARTING DATE	ENDING DATE	TYPE OF CREDITED LEAVE

**NOTE:** You must submit PS Form 3971, *Request for or Notification of Absence*, to your supervisor or manager for any periods listed above.

Attach additional sheets if necessary.

**Health Insurance Benefits – Question 9**

9. Do you want to have Federal Employees Health Benefits (FEHB) coverage?

☒ Yes ☐ No

If YES, indicate which one of the following options you prefer:

☐ Enroll in a new plan or option.

OR

☒ Reinstatement your prior enrollment, retroactive to the date it was terminated.

**Thrift Savings Plan – Questions 10a – 10c**

10a. What was your employment status during the back pay period?

☐ Yes ☐ No

Terminated?

OR

Leave Without Pay (LWOP)?

OR

Denied Postal Service employment (you were not hired)?

☒ Yes ☐ No

☐ Yes ☐ No

If YES to "denied Postal Service employment": Contact the Human Resources Shared Services Center for assistance in completing and submitting the correct documentation.

**Thrift Savings Plan – Questions 10a – 10c continued**

**10b. Do you want to participate in the Thrift Savings Plan (TSP) during the back pay period?**

☒ Yes ☐ No

If YES, you must provide TSP-1 Forms for deductions for participation during the back pay period.

**Note:** The TSP-1 Forms cover only the back pay period. Upon your return to work you must access *PostalEASE* if you wish to participate in TSP and have contributions deducted from your current earnings.

Attach Form(s) TSP-1 and/or Form(s) TSP-1c.

**10c. Did you make one or more Financial Hardship In-Service Withdrawals from your TSP account?**

☐ Yes ☒ No

If NO, go to Question 11:

If YES:

How many Financial Hardship In-Service Withdrawals did you make? \_\_\_\_\_

What is your eligibility date to resume TSP contributions? \_\_\_\_\_

**Note:** Employees are excluded from making TSP contributions for six months (13 pay periods) after receiving a Financial Hardship In-Service Withdrawal. To determine your eligibility date, see the notice you received from the TSP at the time your most recent financial hardship in-service withdrawal was processed. For more information, contact the Human Resources Shared Services Center, or the TSP at 1-877-968-3778.

Attach Form(s) TSP-1 and/or Form(s) TSP-1c with the effective date as your eligibility date.

**Flexible Spending Accounts – Question 11a - 11c**

**11a. Were you enrolled in the Flexible Spending Account (FSA) program prior to the back pay period?**

☒ Yes ☒ No  
2014 2013

**11b. If the answer to 11a is Yes, did your FSA participation end because of reaching eight consecutive pay periods of LWOP or because of termination associated with the back pay?**

☐ Yes ☐ No  
Don't know

**11c. If you answered Yes to 11b, you have two options. Please select either one of the options below (but not both).**

- 1. Do nothing.** If you choose to do nothing, any outstanding invoice for FSA contributions applicable to the back pay period (up to eight consecutive full pay periods) will be adjusted and the amount deducted from your back pay award. You will be eligible for reimbursement from FSA for any qualified claims for expenses for eligible services or items you received through the ending date of FSA participation as it occurred during the back pay period.

☐ Yes ☒ No

Do you choose to do nothing?

- 2.** You can choose to have your FSA participation restored up to the balance of the current Plan year, which ends on December 31 (or, if you subsequently separated from Postal Service employment, the FSA plan year ends the day after your separation). If you choose this option, *in addition to any outstanding invoice for FSA contributions applicable to the back pay period*, you will owe FSA contributions for the additional term of participation and can submit claims for reimbursement for eligible expenses you incurred through the last day of the current Plan year. (Beginning December 31, 2005, if you were an FSA participant on December 31 of each year you may also file claims for expenses for eligible services or items you received during the grace period for each plan year, which is the following January 1 through March 15.)

Do you want to restore your FSA participation for the balance of the Plan year?

☒ Yes ☐ No

**Note:** If you missed FSA Open Season enrollment during the back pay period and would like to begin participation now, please contact the Human Resources Shared Services Center.

**Postal Service Indebtedness – Question 12**

12. Do you have any outstanding indebtedness to the Postal Service that is not related to the period of your back pay award?

☐ Yes ☒ No

If YES, please indicate the amount, if any, you would like deducted from your final award.

\$ \_\_\_\_\_

**Life Insurance**

**Eligibility for life insurance coverage after a return to pay and duty status is determined by the law and regulations for the Federal Employees' Group Life Insurance (FEGLI) Program, administered by the Office of Personnel Management (OPM).**

For detailed information on how FEGLI handles coverage in such situations, and what options are available to a Postal Service employee, see *Employee and Labor Relations Manual (ELM)* 436.5, Life Insurance Coverage.

**C. Privacy Act Statement**

Your information will be used to determine the amount of back pay you are entitled to receive under a decision/award or settlement agreement authorized by an appropriate authority. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004, 1005, and 1026; and 29 U.S.C. 2601 *et seq.* Providing this information is voluntary, but if not provided, we may not be able to process your back pay claim.

We may only disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local, or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; and to federal, state, or local governments administering benefit or other programs to conduct a computer match to verify eligibility, indebtedness, or compliance with requirements of the program.

**Civil Penalty for Presenting False or Fraudulent Claim:**

A person who submits a false or fraudulent claim is liable for a civil penalty of not less than \$5,000 and not more than \$10,000, plus an amount equal to three times the amount of damages sustained due to the false or fraudulent claim, and the costs of any civil action brought to recover such amounts (see 31 USC 3729-3731).

**Criminal Penalty for Presenting False or Fraudulent Claim or Making False or Fraudulent Statements:**

A person who submits a false or fraudulent claim or makes a false or fraudulent statement is liable for a criminal fine or imprisonment for not more than 5 years or both (see 18 USC 287, 1001).

**D. Employee Signature**

I hereby certify that my answers to the above questions are true and correct to the best of my knowledge and belief, and I understand the above provisions regarding the Privacy Act Statement and the civil and criminal penalties for presenting false or fraudulent claims or making false or fraudulent statements.

  
Signature

9 June 2014  
Date







## Prearbitration or Agency Settlement Worksheet

**Instructions:** This form expedites processing of lump sum payments from pre-arbitration, pre-trial, and administrative agency settlement agreements. If the payment is for other than lump sum payments (for example, adjustments to hours or benefits), use **PS Form 8039, Back Pay Decision/Settlement Worksheet**. You must complete all sections of this form before Accounting Services will process the payment. Please print legibly or type when completing this form. A copy of the settlement agreement must accompany this form.

### I. Employee Identification

Name (Last, First, MI) <b>McDermott, Lance P</b>			Employee Identification Number (EIN) (Use SSN if EIN is unavailable) <b>03272132</b>		
Period covered by the settlement: From: (MM/DD/YYYY) <b>30/05/2013</b> To: (MM/DD/YYYY) <b>01/03/2014</b>			Grievance/Case Number (See Exhibit 6) <b>E10T-1E-C13332927</b>		
Designation/Activity Code (DES/ACT) <b>1618</b>			Finance Number (to be charged) <b>54-7649</b>		
Employing Office Address (Number, street, suite, etc.) <b>22430 Russell Road, Bldg "C"</b>			Employing Office Telephone Number (include Area Code and Extension) <b>253-437-2198</b>		
City <b>Kent</b>	State <b>WA</b>	ZIP+4® <b>98032</b>	USPS® Contact Office Address (Number, street, suite, etc.)		
USPS Labor Relations, Human Resources, or Law Office Contact <b>Jean Wise Carver</b> <b>(206) 381-6692</b>			City	State	ZIP+4
City	State	ZIP+4	USPS Contact Telephone Number (include Area Code and Extension)		

### II. Settlement Information

Date of Settlement: (MM/DD/YYYY) <b>11/03/2014</b>	Relevant Pay Period: (PP/YYYY) <b>13/2013 to 07/2014</b>	Lump sum amount to be paid: <b>\$ 72,167</b>
What was the forum of this settlement?		

- ☐ Pre-arbitration  
☐ Pre-trial  
☐ Equal Employment Opportunity Commission (EEOC)  
☐ Merit Systems Protection Board (MSPB)  
☒ Other (specify): **\* SEE EXHIBIT 2+3 \***

### III. Interest, Non-wage Income, and Reimbursable Expenses (if applicable)

**Note:** Issue a separate check for each. Issue IRS Form 1099-INT, Interest Income, for (A). Issue IRS Form 1099-MISC, Miscellaneous Income, for (B). IRS reporting requirements vary for reimbursable expenses listed in item (C). Advise employee to consult with a qualified income tax advisor for more information.

A) Was interest expressly awarded in the settlement?

- ☐ Yes (interest is computed on the lump sum amount)  
☒ No



**III. Interest, Non-wage Income, and Reimbursable Expenses (if applicable) — continued**

B) Is any portion of this lump sum payment for non-wage income (e.g. attorneys' fees) that is excluded from deductions and withholding?

☐ Yes

☒ No

If yes, what amount of the lump sum payment is for non-wage income?

\$ \_\_\_\_\_

C) Is any portion of this lump sum payment for reimbursable expenses (e.g., travel), including per diem and/or mileage?

☐ Yes

☒ No

If yes, what amount of the lump sum payment is for reimbursable expenses?

\$ \_\_\_\_\_

**IV. Special Instructions**

Please list any special instructions: (e.g., mailing instructions or joint name on payments)

**NOTE:** Lump sum back pay awards are typically mailed to the address of record for the finance number expensed. Alternative mailing arrangements are not available unless the settlement specifically directs other mailing procedures, or the payment is for interest, non-wage income, or reimbursable expenses. Payments for interest, non-wage income and reimbursable expenses will be mailed directly to the employee.

**V. Signatures**

Certifying official's name and title (please print)

Signature

Date (MM/DD/YYYY)

**VI. Mailing Instructions**

If the amount is less than \$1,500, mail to:

Accounting Services  
Payroll Services – Pay Location 9631  
2825 Lone Oak Parkway  
Eagan MN 55121-9631

If payment is for \$1,500 or more, or includes interest, non-wage income, or reimbursable expenses, mail to:

Accounting Services  
Financial Processing – Pay Location 9616  
2825 Lone Oak Parkway  
Eagan MN 55121-9616

IDENTIFICATION PURPOSES

SAFEGUARD IT.

AREAS RENDER FORM 1

## CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle) MODERMOTT, LANCE PATRICK		2. DEPARTMENT, COMPONENT AND BRANCH ARMY/ARNG/TC		3. SOCIAL SECURITY 538 68 992																																					
4. GRADE, RATE OR RANK 1LT	4.6. PAY GRADE 02	5. DATE OF BIRTH (YYMMDD) 590415		6. RESERVE OBLIG. TERM. DATE Year 00 Month 00 Day																																					
7.a. PLACE OF ENTRY INTO ACTIVE DUTY TACOMA, WA		7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or comp address if known) 11413 CORNELL AVE. S. SEATTLE, WA 98178																																							
8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 116th CS CTR RAOC (WTBYAA)/USARCENTI (CT)		8.b. STATION WHERE SEPARATED FT. LEWIS, WA 98435-5000																																							
9. COMMAND TO WHICH TRANSFERRED 711 S YAKIMA, TACOMA WA 98406		10. SGLI COVERAGE Amount: \$ 100,000.00																																							
11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one year or more.) 88A TRANSPORTATION, GENERAL//NOTHING FOLLOWS		12. RECORD OF SERVICE																																							
		<table border="1"> <thead> <tr> <th></th> <th>Year(s)</th> <th>Month(s)</th> <th>Day</th> </tr> </thead> <tbody> <tr> <td>a. Date Entered AD This Period</td> <td>80</td> <td>12</td> <td>06</td> </tr> <tr> <td>b. Separation Date This Period</td> <td>81</td> <td>07</td> <td>12</td> </tr> <tr> <td>c. Net Active Service This Period</td> <td>00</td> <td>07</td> <td>07</td> </tr> <tr> <td>d. Total Prior Active Service</td> <td>03</td> <td>08</td> <td>12</td> </tr> <tr> <td>e. Total Prior Inactive Service</td> <td>00</td> <td>00</td> <td>00</td> </tr> <tr> <td>f. Foreign Service</td> <td>SEE</td> <td>BLOCK</td> <td>71</td> </tr> <tr> <td>g. Sea Service</td> <td>00</td> <td>00</td> <td>00</td> </tr> <tr> <td>h. Effective Date of Pay Grade</td> <td>80</td> <td>07</td> <td>21</td> </tr> </tbody> </table>					Year(s)	Month(s)	Day	a. Date Entered AD This Period	80	12	06	b. Separation Date This Period	81	07	12	c. Net Active Service This Period	00	07	07	d. Total Prior Active Service	03	08	12	e. Total Prior Inactive Service	00	00	00	f. Foreign Service	SEE	BLOCK	71	g. Sea Service	00	00	00	h. Effective Date of Pay Grade	80	07	21
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e. Total Prior Inactive Service	00	00	00																																						
f. Foreign Service	SEE	BLOCK	71																																						
g. Sea Service	00	00	00																																						
h. Effective Date of Pay Grade	80	07	21																																						
13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service) ARMY SERVICE RIBBON//ARMY LAPEL BUTTON//NATIONAL DEFENSE SERVICE MEDAL//DRIVERS AND MECHANICS BADGE W/ WHEEL// SOUTHWEST ASIA SERVICE MEDAL//NOTHING FOLLOWS																																									
14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed) NONE//NOTHING FOLLOWS																																									
15.a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS EDUCATIONAL ASSISTANCE PROGRAM		Yes	No	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT																																					
			X	Yes																																					
				No																																					
16. DAYS ACCRUED LEAVE PRIOR TO SEPARATION																																									
17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION																																									
18. REMARKS ORDERED TO ACTIVE DUTY IN SUPPORT OF OPERATION DESERT SHIELD/DESERT STORM IAW USC 8732/12012 ABOVE DOES NOT ACCOUNT FOR ANNUAL AND/OR WEEKEND TRAINING THIS SOLDIER MAY HAVE ACCOMPLISHED PRIOR TO DATE ENTERED IN ITEM 12A//SOLDIER SERVED IN SOUTH WEST ASI 910117 THROUGH 910618//INDIVIDUAL COMPLETED PERIOD FOR WHICH ORDERED TO AD FOR PURPOSE OF POST SERVICE BENEFITS AND ENTITLEMENTS//NOTHING FOLLOWS																																									
19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code) ADDRESS SAME AS BLOCK 7B		19.b. NEAREST RELATIVE (Name and address include Zip Code) DARLENE MCDERMOTT ADDRESS SAME AS BLOCK 7B																																							
20. MEMBER REQUESTS COPY 5 BE SENT TO WA		21. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title, signature) RONALD G. HILL, CPT, AG, PERS MGT OFF																																							
21. SIGNATURE OF MEMBER BEING SEPARATED Lance P. Mc Dermott																																									
SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)																																									
23. TYPE OF SEPARATION RELEASE FROM ACTIVE DUTY		24. CHARACTER OF SERVICE (Include upgrades) HONORABLE																																							
25. SEPARATION AUTHORITY AR 635 - 100, Chapter 4		26. SEPARATION CODE LBK		27. REENTRY CODE NA																																					
28. NARRATIVE REASON FOR SEPARATION EXPIRATION TERM OF SERVICE																																									
29. DATES OF TIME LOST DURING THIS PERIOD NONE																																									
30. MEMBER REQUESTS CC CM																																									



01 EFFECTIVE DATE  
03-11-2014

## Notification of Personnel Action

02 SOCIAL SECURITY NUMBER  
538-66-9927

### EMPLOYEE INFORMATION

03	EMPLOYEE NAME-LAST	MCDERMOTT
04	EMPLOYEE NAME-FIRST	LANCE
05	EMPLOYEE NAME-MIDDLE	P
06	MAILING ADDRESS STREET/BOX/APT	1819 S 104TH ST
07	MAILING ADDRESS-CITY	SEATTLE
08	MAILING ADDRESS-STATE	WA
09	MAILING ADDRESS-ZIP+4	98168-1647
10	DATE OF BIRTH	04-15-1959
11	VETERANS PREFERENCE	01 - NO PREFERENCE
12	SEX	M
13	ETHNICITY - RACE	WHITE-NOT HISP
14	DISABILITY	05
15	LEAVE COMP DATE	03-15-1994
16	ENTER ON DUTY DATE	01-27-1997
17	RETIREMENT COMP DATE	03-15-1997
18	SERV ANNIVERSARY PPYR	07-1997
19	TSP ELIGIBILITY	
20	TSP SERVICE COMP DATE	12-18-1996
21	PRIOR CSRS SERVICE	
22	FROZEN CSRS TIME	
23	LEAVE DATA-CATEGORY	8.00-HOURS/PP
24	LEAVE DATA-CHG PPYR	
25	LEAVE DATA-TYPE	01-ADVANCE AL - EARN SL
26	CREDIT MILITARY SERV	
27	reserved for future use	
28	RETIREMENT PLAN	8-FERS
29	EMPLOYMENT STATUS	
30	LIFE INSURANCE	C0+BASIC
31	SPECIAL BENEFITS	

### POSITION INFORMATION

32	EMPLOY OFFICE-FIN NO	547649
33	EMPLOY OFFICE-NAME	SEATTLE PRIORITY MAI
34	EMPLOY OFFICE-ADDRESS	KENT WA 980324809
35	DUTY STATION-FIN NO	547649
36	DUTY STATION-NAME	SEATTLE PRIORITY MAI
37	APPT EXPIRATION DATE	

38	PROBATION EXPIR DATE	
39	FLSA STATUS	N - NON-EXEMPT
40	PAY LOCATION	715
41	RURAL CARRIER ROUTE	
42	RURAL CARR-L-RTE-ID	
43	RURAL CARR-PAY TYPE	
45	RURAL CARR-FLSA	
46	RURAL CARR-COMMIT	
47	RURAL CARR-EMA	
48	RURAL CARR-HOURS	
49	RURAL CARR-MILES	
50	JOB SEQUENCE	
51	OCCUPATION CODE	5350-0001
52	POSITION TITLE	MAINT MECH MPE
53	LABOR DIST CODE	36
54	DESIGNATION/ACTIVITY	16/8
55	POSITION TYPE	1 - FULL TIME
56	LIMIT HOURS	
57	ALLOWANCE CODE	
58	EMPLOYMENT TYPE	V - VRA HIRING AUTHORITY

### SALARY INFORMATION

59	PAY RATE CODE	A - ANNUAL RATE
60	RATE SCHEDULE CODE	P - POSTAL SERVICE SCH-2
61	GRADE/STEP	09/P
62	BASE SALARY	50,067
63	COLA	
64	COLA ROLL-IN IND	
65	NEXT STEP PPYR	
66	MERIT ANNIV DATE	
67	MERIT LUMP SUM	
68	SPECIAL SALARY CODE	
69	PROTECTED RSC	
70	PROTECTED GRADE/STEP	
71	EXPIRATION PPYR	
72	PROTECTED RC HOURS	
73	PROTECTED RC MILES	
74	RC GUARANTEED SALARY	
75	ANNUITY AMOUNT	

### NATURE OF PERSONNEL ACTION

77	NATURE OF ACTION CODE	292	78	AUTHORITY	
79	DESCRIPTION	RETURN TO DUTY			
80	CODE	81	CODE	82	CODE
83	CODE	84	CODE	85	CODE
84	REMARKS				

PERSON ID:03272132 PERS ASSGN:03272132  
RECEIVED NOTIFICATION FROM W.R. SUDDUTH,SEATTLE DISTRICT TO RETURN EMPLOYEE  
TO DUTY EFFECTIVE 03/11/2014 FROM REGULAR LWOP. REMEDY INC 7925389 HRSSC,  
MRTHOMAS, PPS, 3/14/2014

85	AUTHORIZATION MANAGER, HUMAN RESOURCES SHARED SERVICE CENTER	86	PROCESSED DATE	03-14-2014
		87	PERSONNEL OFFICE ID	
		88	OFF LOCATION	



01 EFFECTIVE DATE  
09-15-2013

## Notification of Personnel Action

02 SOCIAL SECURITY NUMBER  
538-66-9927

### EMPLOYEE INFORMATION

03	EMPLOYEE NAME-LAST	MCDERMOTT
04	EMPLOYEE NAME-FIRST	LANCE
05	EMPLOYEE NAME-MIDDLE	P
06	MAILING ADDRESS STREET/BOX/APT	1819 S 104TH ST
07	MAILING ADDRESS-CITY	SEATTLE
08	MAILING ADDRESS-STATE	WA
09	MAILING ADDRESS-ZIP+4	98168-1647
10	DATE OF BIRTH	04-15-1959
11	VETERANS PREFERENCE	01 - NO PREFERENCE
12	SEX	M
13	ETHNICITY - RACE	WHITE-NOT HISP
14	DISABILITY	05
15	LEAVE COMP DATE	03-15-1994
16	ENTER ON DUTY DATE	01-27-1997
17	RETIREMENT COMP DATE	03-15-1997
18	SERV ANNIVERSARY PPYR	07-1997
19	TSP ELIGIBILITY	
20	TSP SERVICE COMP DATE	12-18-1996
21	PRIOR CSRS SERVICE	
22	FROZEN CSRS TIME	
23	LEAVE DATA-CATEGORY	8.00-HOURS/PP
24	LEAVE DATA-CHG PPYR	
25	LEAVE DATA-TYPE	01-ADVANCE AL - EARN SL
26	CREDIT MILITARY SERV	
27	reserved for future use	
28	RETIREMENT PLAN	8-FERS
29	EMPLOYMENT STATUS	LW-LEAVE W/O PAY
30	LIFE INSURANCE	C0+BASIC
31	SPECIAL BENEFITS	

### POSITION INFORMATION

32	EMPLOY OFFICE-FIN NO	547649
33	EMPLOY OFFICE-NAME	SEATTLE PRIORITY MAI
34	EMPLOY OFFICE-ADDRESS	KENT WA 980324809
35	DUTY STATION-FIN NO	547649
36	DUTY STATION-NAME	SEATTLE PRIORITY MAI
37	APPT EXPIRATION DATE	

38	PROBATION EXPIR DATE	
39	FLSA STATUS	N - NON-EXEMPT
40	PAY LOCATION	715
41	RURAL CARRIER ROUTE	
42	RURAL CARR-L-ATE-ID	
43	RURAL CARR-PAY TYPE	
45	RURAL CARR-FLSA	
46	RURAL CARR-COMMIT	
47	RURAL CARR-EMA	
48	RURAL CARR-HOURS	
49	RURAL CARR-MILES	
50	JOB SEQUENCE	
51	OCCUPATION CODE	5350-0001
52	POSITION TITLE	MAINT MECH MPE
53	LABOR DIST CODE	96
54	DESIGNATION/ACTIVITY	16/8
55	POSITION TYPE	1 - FULL TIME
56	LIMIT HOURS	
57	ALLOWANCE CODE	
58	EMPLOYMENT TYPE	V - VRA HIRING AUTHORITY

### SALARY INFORMATION

59	PAY RATE CODE	A - ANNUAL RATE
60	RATE SCHEDULE CODE	P - POSTAL SERVICE SCH-2
61	GRADE/STEP	09/ P
62	BASE SALARY	59,205
63	COLA	
64	COLA ROLL-IN IND	
65	NEXT STEP PPYR	
66	MERIT ANNIV DATE	
67	MERIT LUMP SUM	
68	SPECIAL SALARY CODE	
69	PROTECTED RSC	
70	PROTECTED GRADE/STEP	
71	EXPIRATION PPYR	
72	PROTECTED RC HOURS	
73	PROTECTED RC MILES	
74	RC GUARANTEED SALARY	
75	ANNUITY AMOUNT	

### NATURE OF PERSONNEL ACTION

77	NATURE OF ACTION CODE	460	78	AUTHORITY	
79	DESCRIPTION	LWOP (EXCEEDING 30 CALENDAR DAYS)			
80	CODE	81	CODE	82	CODE
83	CODE	84	CODE	85	CODE
84	REMARKS				

PERSON ID:03272132 PERS ASSGN:03272132  
EMPLOYEE PLACED ON REGULAR LWOP. PER TACS. EMPLOYEE NON PAY STATUS BEGINS  
EFFECTIVE 09 15 2013. REMEDY INC 7810837. HRSSC, KMCKANE, PPS, 02 10 2014

85	AUTHORIZATION	86	PROCESSED DATE	02-10-2014
	MANAGER, HUMAN RESOURCES	87	PERSONNEL OFFICE ID	
	SHARED SERVICE CENTER	88	OFF LOCATION	



February 11, 2014

Lance McDermott  
1819 S 104<sup>th</sup> Street  
Seattle, WA 98168

Mr. McDermott:

Your placement on enforced leave was the direct result of your refusal to interact with management on the issue of your medical limitations (*i.e.* color blindness). Should you decide that you would like to interact with management, please feel free to contact Jim Norris or Dave Marzec. You continue to have the right to request reasonable accommodation and/or light duty. However, as previously explained, you must avail yourself of one of these options, including a willingness to sit down and discuss your medical limitations, if any, and the impact of your medical limitations on the performance of the essential functions of your job. Absent your participation, management cannot make a proper determination and cannot return you to work. I encourage you to avail yourself of your options.

Sincerely,

A handwritten signature in black ink, appearing to read "Alexis Delgado".

Alexis Delgado  
Manager, Human Resources – Seattle District

CC:  
Maintenance Manager Lead – Seattle P&DC  
Occupational Health Nurse Administrator (OHNA) – Seattle District  
Manager, Labor Relations – Seattle District



MANAGER MAINTENANCE



March 6, 2014

Lance McDermott  
1819 S. 104<sup>th</sup> Street  
Seattle, WA 98168

Dear Mr. McDermott:

Recently, you contacted us and expressed your willingness to come in and discuss your medical limitations, i.e., color-blindness, and the impact of your limitations on the performance of your duties. As a result, on Tuesday March 4, 2014, you met with Manager Maintenance Operations William (Rick) Sudduth.

You advised Rick that you have difficulty distinguishing between shades of colors, but not primary colors. Rick presented you with various colors of wires and you successfully identified all of them. You provided Rick with documentation showing that had failed the Ishihara test, meaning that you were unable distinguish a number amongst color dots. However, you successfully passed the Lantern test, demonstrating your ability to distinguish between primary colors.

Based on this information you provided, I am instructing you to report back to work to resume the duties of your position of Maintenance Mechanic MPE as soon as you can. I further instruct that if you are required to do any electrical work which involves distinguishing shades of colors, that you seek confirmation of the colors from either a co-worker and/or supervisor.

Your safety record is commendable and it is my goal to ensure you continue your satisfactory safety record.

In order to make your return to work as smooth as possible please contact William (Rick) Sudduth at 206-768-4478 to secure your access badge and to ensure your timecard is available at your facility.

You may contact me at 206-768-4480 if you have any concerns regarding my decision.

Sincerely

A handwritten signature in black ink, appearing to read "Jim Norris".

Jim Norris  
Manager Maintenance Lead, Seattle P

File

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Page 1 of 1

## Statement

USPS DISBURSING OFFICER  
ACCOUNTING SERVICE CENTER  
2825 LONE OAK PKWY  
EAGAN MN 55121-9640

STATEMENT DATE: 20-MAR-2014  
CUSTOMER NUMBER: 03272132  
TOTAL DUE: \$ 1,090.41

LANCE P MCDERMOTT  
1819 S 104TH ST  
SEATTLE WA 98168-1647

Questions or correspondence:  
YOUR EMPLOYING OFFICE MAY CONTACT US AT  
651 681-1404 IF ADDITIONAL ASSISTANCE IS  
NEEDED.  
MAKE CHECK PAYABLE TO: US POSTAL SERVICE

TRANSACTION NUMBER	DATE	TRANSACTION TYPE	DUE DATE	REFERENCE	TRANSACTION AMOUNT	AMOUNT DUE
1467069	19-FEB-14	Invoice	21-MAR-14	Q44540 PRD	276.91	276.91
702529416	26-FEB-14	Invoice	28-MAR-14	P42870 PRD	813.50	813.50
						<b>TOTAL DUE</b>
						1,090.41

Current	1-30 Days	31-60 Days	61-90 Days	Over 90 Days	FINANCE CHARGES	TOTAL DUE
1,090.41	0.00	0.00	0.00	0.00	0.00	1,090.41

To ensure proper credit to your account, please return bottom portion with your remittance



ATTN: FINANCIAL PROCESSING  
ACCOUNTING SERVICE CENTER  
2825 LONE OAK PKWY  
EAGAN MN 55121-9616

STATEMENT DATE: 20-MAR-2014  
CUSTOMER NUMBER: 03272132  
TOTAL DUE: \$ 1,090.41

AMOUNT PAID: \$ \_\_\_\_\_



LANCE P MCDERMOTT  
1819 S 104TH ST  
SEATTLE WA 98168-1647

MAIL TO:



USPS DISBURSING OFFICER  
ACCOUNTING SERVICE CENTER  
2825 LONE OAK PKWY  
EAGAN MN 55121-9640

☐ Check here to change address, complete new address on reverse.  
Write your customer number on your check or money order. Do not send cash.

4





May 30, 2013

Lance McDermott  
1819 S. 104<sup>th</sup> St.  
Seattle, WA 98168

On May 8, 2013, you received a notice proposing to place you on enforced leave from the Postal Service due to your medical condition (color blindness).

I have received no response from you, however, I have reviewed the correspondence previously provided to you and the evidence of record. I find that the action proposed in the notice of proposed enforced leave is supported by the evidence and warrant(s) your placement on enforced leave.

I do not take this action lightly. Previously, due to an operational change, you relayed to management that you could not distinguish colors; i.e. you were color blind and, therefore, could not perform the functions necessitated by the operational change.

As a result of your disclosure, your supervisors sought to discuss with you other essential aspects of your employment impacted by the inability to distinguish colors; most importantly, the ability to distinguish colored wiring when working on machinery. You rebuffed every attempt; refusing to request light duty, refusing to participate in the reasonable accommodation process, and otherwise refusing to discuss this matter at all.

It was made clear to you that while such discussions are wholly voluntary, without your participation and cooperation, it is not possible to evaluate whether you can perform the essential functions of your position with or without accommodation. In other words, we simply do not know whether you can perform your duties in a safe manner, and, what, if any, accommodations can be made, if you refuse to interact. As a result, your placement on enforced leave is warranted.

This action will be effective 5-30-2013.

I want to make clear that your placement on enforced leave is a direct result of your refusal to interact with management on this very important issue. Should you decide that you would like to interact with management, please feel free to contact myself or Dave Marzec. You continue to have the right to request reasonable accommodation and/or light duty. However, as previously mentioned, you must avail yourself of these options which includes a willingness to sit down and discuss your medical limitations, if any, and the impact of your medical limitations on the performance of the essential functions of your job. Absent your participation, management cannot make a proper determination. By and through this letter, I encourage you to avail yourself of your options.

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If you are a preference eligible employee, you may have a right to appeal this decision in writing to the Merit Systems Protection Board (MSPB) within 30 calendar days from your receipt of this decision. If you appeal to the MSPB, please provide me a copy of your appeal. Your appeal to the MSPB should state whether you do or do not wish a hearing and you should furnish me a copy of your appeal. For further information on appeals procedures, contact Regina Beckham, Mgr. Labor Relations, at 253-214-1735. MSPB regulations and appeal forms are available on-line at: [www.mspb.gov](http://www.mspb.gov) The address for the MSPB is as follows:

MSPB Western Regional Office  
201 Mission St., Suite 2310  
San Francisco CA 94105-1831

If you do not appeal to the MSPB within the above time limit, you will have no further appeal right with the MSPB. If you appeal to the MSPB, please provide me a copy of your appeal.

If you believe that the action is based, in whole or in part, on discrimination, you have the option of filing an appeal with the MSPB, or filing an EEO complaint with the Postal Service.

To file an EEO complaint, you must request counseling within 45-calendar days of the effective date of this decision. You may request counseling by calling (888) 336-8777. The EEO complaint will be processed pursuant to the appropriate regulations (29 C.F.R. §§ 1614.302 through 1614.310).

If you file an MSPB appeal you are not entitled to a hearing by the Equal Employment Opportunity commission (EEOC) unless:

1. Your appeal to the MSPB is dismissed for lack of jurisdiction; or
2. The Postal Service fails to issue a final agency decision on your EEO complaint within 120 days of the date you filed your EEO complaint.

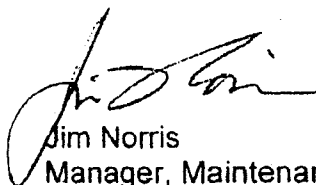
You may request a hearing by the MSPB after the Postal Service has rendered a decision on your EEO complaint or after 120-calendar days from filing your EEO complaint, whichever occurs first. If you appeal this action you will remain on the rolls in a non-pay, non-duty status until disposition of your case has been reached – either by settlement or through exhaustion of your administrative remedies.

If this action is reversed or modified on appeal by the MSPB or EEOC, back pay may be allowed in accordance with 5 C.F.R. §§ 550.801 through 550.808, as applicable, unless the award or decision specifies otherwise.

If this decision is reversed or modified through an adverse decision, back pay may be allowed, unless the award or settlement specifies otherwise, only if you have made

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reasonable efforts to obtain alternate employment during the potential back pay period. The documentation which you must maintain and present to support a back pay claim is described in Part 436 of the Employee and Labor Relations Manual.



Jim Norris  
Manager, Maintenance Lead  
(206) 768-4480

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LABOR RELATIONS  
SEATTLE P&DC



**RECEIVED**

**Step 2 Grievance Decision**

**OCT 11 2013**

October 9, 2013

**GSAL-APWU**

Installation: Seattle P & DC  
Installation Finance #: 54-7618  
Grievant's Name: McDermott, Lance  
Grievant's EID: 03272132  
Incident Date: 9/1/13  
Local Union Grievance: MNT-103-13  
Management Grievance: E10T-1E-C13332927  
Subject: Enforced Leave  
Issue Code: 10.5195

**Denied**

Myrna Umali  
President, Seattle APWU  
PO 48148  
Burien, WA 98148-0148

Dear Ms. Umali:

The above referenced grievance was discussed at Step 2 of the grievance procedure with your representative Lester Cornette on 09/30/13.

**Issue:** The grievance concerns Management's alleged violation of Article 5, 11, 19 by placing Lance McDermott on Enforced Leave on May 30, 2013. In addition, Lance McDermott was not paid for hours worked on Sunday September 1, 2013 and Holiday leave for September 2, 2013.

**Background:** Lance McDermott was placed on enforced leave on May 30, 2013, after several failed attempts by management to engage Mr. McDermott in a discussion on whether or not he could safely perform essential aspects of his position, due to a permanent restriction concerning his vision. Specifically, his ability to distinguish between certain colors and shades of color. Management needs to determine if and how this difficulty in distinguishing certain colors impedes him from safely working on the electrical circuits, and wiring of the machinery he works on. Management was made aware of his visual impairment on February 5, 2013 and has been trying to resolve the issue with Mr. McDermott since then.

On September 1, 2013 Mr. McDermott came into the Seattle Priority Mail Annex while on enforced leave. Mr. McDermott was not on the work schedule, and had not contacted Management about his returning to work. He was escorted off the property by the Postal Inspection Service after it was reported to them that his presence there was unauthorized. He had previously been escorted off the premises on July 1, 2013 by the Postal Inspection Service under similar circumstances.

Mr. McDermott is currently appealing his placement on enforced leave to the Merit Systems Protection Board.

**Remedy:** "Return employee 'back to work immediately' and reimburse 700 hours of annual leave and 250 hours of sick leave for having to use his livelihood. Compensate \$460.00 for 1 September and 2 September 2013 Labor day holiday (16 hours). Have management cease this type action and not to retaliate against employee, even though this will happen, move Supervisor Dow to another facility for he is a detriment to employees and the USPS at the USPS at the PMA. This is his 4<sup>th</sup> employee he has gone after and all 4 are stewards, (a pattern indeed)."

6

- 2 -

**Union Contentions:** The Union reiterated its written contentions at the Step 2 meeting. The Union stressed two main contentions at the Step 2 meeting. The first is that Mr. McDermott has been on enforced leave longer than fourteen days and this is a 'constructive suspension' which is appealable to the Merit System Protection Board, and is therefore the enforced leave is procedurally defective. The Union further contends that Yul Melonson, Seattle District Manager, needed to concur with the letter from James Norris, Manager, Maintenance Lead for the Seattle District, placing Mr. McDermott on enforced leave.

The Union also contends that Mr. McDermott should be paid for September 1, 2013, his sick leave reimbursed for that day, and that he be paid 8 hours holiday pay for September 2, 2013 (Labor Day).

**Management's Position:** The union's arguments were taken into consideration. This is a contract grievance, and as such, the burden of proof rests with the union. The union must show, by the weight of the evidence, that management either (1) violated the clear, express language of the contract, or (2) was arbitrary, capricious and unreasonable in their administration of the contract.

Management contends that this grievance is grossly untimely, and is therefore procedurally defective. Mr. McDermott was placed on enforced leave effective May 30, 2013. In his appeal to the Merit System Protection Board, submitted on 6/25/13 Mr. McDermott indicated that neither he, nor anyone else on his behalf, had filed a grievance under a negotiated grievance procedure provided by a collective bargaining agreement. Then on September 20, 2013 the Union initiated a grievance at Step 1. This date is considerably beyond 14 days of the date (5/30/13) that the employee first learned of its cause.

Management contends that as the Lead Maintenance Manager for the Seattle District, James Norris is the Senior Maintenance official in the district over Mr. McDermott, and that he is the appropriate Manager to issue the letter of proposed placement on enforced leave to Mr. McDermott. Management contends that Mr. Norris is a designee for Mr. Melonson in matters of this nature.


Management contends that Mr. McDermott was not on the schedule to work on September 1, 2013, and he was not authorized to be in the building. Mr. McDermott did not do a begin tour for that day. Mr. McDermott was not assigned any work for that day, and he did not do any work for the time he was in the building. Management contends that given these circumstances, he should not be paid for his unauthorized presence in the building. Mr. McDermott was on enforced leave for this time, and he continues to be on enforced leave at the present time. Management contends that all Mr. McDermott has to do in order to come back to work is to engage in discussions with management in order to evaluate whether or not he can perform the essential functions of his position with or without accommodation. Mr. McDermott has refused to interact with management to resolve this issue, and continues to refuse to do so at this time.

Management contends that the issues related to enforced leave are the subject of an appeal to the Merit System Protection Board, and that a hearing on this matter will be held in the very near future. Management contends that this appeal is the appropriate forum to contest the issue of enforced leave.

Management contends that the Union's arguments did not demonstrate any violation of the contract language and therefore, their burden of proof has not been met.

**Decision:** Based on the above stated facts, the Union's grievance is hereby **Denied**.

Sincerely,

  
David J. Marzec, MMO  
Step 2 Designee

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Instance code: 10

# Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor  
Employment Standards Administration  
Wage and Hour Division



OMB Control Number: 1215-0181  
Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

## [Part A - NOTICE OF ELIGIBILITY]

EIN 03272132 Case# 110000402232

TO: Lance P Mcdermott  
Employee  
1819 S 104TH ST  
SEATTLE, WA 98168-1647

FROM: FMLA SPECIALIST@ PO BOX 970910 GREENSBORO, NC 27497-0910  
Employer Representative

DATE: 02/21/2013

On 02/20/2013, you informed us that you needed leave beginning on 02/20/2013 for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☒ Your own serious health condition;
- ☐ Because you are needed to care for your \_\_\_\_\_ spouse; \_\_\_\_\_ child; \_\_\_\_\_ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- ☐ Because you are the \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent; \_\_\_\_\_ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- ☒ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- ☐ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_\_\_ months towards this requirement.
- ☐ You have not met the FMLA's 1,250-hours-worked requirement.
- ☐ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact FMLA SPECIALIST@877-477-3273 Option 5 Fax 651-456-6071 or view the  
FMLA poster located in YOUR WORK UNIT

## [PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- ☐ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request \_\_\_\_\_ is/ \_\_\_\_\_ is not enclosed.
- ☐ Sufficient documentation to establish the required relationship between you and your family member
- ☐ Other information needed: \_\_\_\_\_

No additional information requested

CONTINUED ON NEXT PAGE

Form WH-381 Revised January 2009

Seattle District



August 21, 2013

Lance P. McDermott  
1819 S 104<sup>th</sup> ST  
Seattle WA 98168-1647

EID #03272132

RE: Return-to-Work (RTW) Documentation

Mr. McDermott

As requested in our telephone conversation this morning, the optional RTW forms SPO69A and *Work Restriction*, SPO69B, are enclosed. Documentation on your health care provider's letterhead is acceptable.

The documentation should be submitted to your Supervisor or Manager.

If there are any questions, please contact me or your Supervisor/Manager.

Respectfully

A handwritten signature in black ink, appearing to read "Tanya L. Daniels".

Tanya L. Daniels RN  
Occupational Health Nurse Administrator

cc: D. Marzec MMO  
file

Tracking #9114 9010 7574 2955 7720 67



POSTAL SERVICE

## RETURN-TO-WORK CLEARANCE

(For non-work related conditions)Completed by treating, licensed health care provider.Employee's Name Lance P. McDermott Last 4 of SSN/EID # 03272132

- Date the condition started birth
- The nature of the condition\*\* that kept the employee off work color blindness

\*\*This form is intended to be returned to the employee's Supervisor. Please limit the information to a general issue/condition or procedure such as left foot, right elbow, abdominal surgery, etc. A specific diagnosis is not required.

- Hospitalization: No ☒ Yes ☐ Date of Admission \_\_\_\_\_ Date of Official Discharge \_\_\_\_\_

Any/All Government Driving

- The employee can resume Full Driving Duties without restrictions: Yes ☒ No ☐ If 'no', please explain \_\_\_\_\_

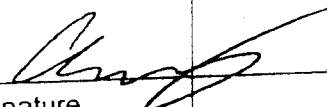
- Does the employee's condition or treatment pose a workplace hazard to the employee or to others? No ☒ Yes ☐  
If "yes", please explain \_\_\_\_\_

Complete One

- Date employee may return to work without work restrictions 09/01/13
- Date employee may return to work with work restrictions \_\_\_\_\_  
Please complete SPO-69 B Work Restrictions only if work restrictions are needed.

**Andrew Selby, PA-C**

Treating Health Care Provider (Printed Name and Address)

Signature 

RIVERTON FAMILY MEDICINE  
13030 Military Rd S #210  
Tukwila, WA 98168  
Tel: 206-242-8500 Fax: 206-246-7946

Fax

Date

08/28/13

7



COMPLETED BY EMPLOYEE/SUPERVISOR

Employee Name Lance P. McDermott EID # 03272132 Condition/Issue \_\_\_\_\_ Onset \_\_\_\_\_  
 Work Location/Facility Seattle PMA Craft MPE Pay Location 715 Supervisor \_\_\_\_\_

COMPLETED BY HEALTH CARE PROVIDER

Date Employee May Return to Work 09/01/13 CHECK ONE: ☒ FULL DUTY No work restrictions are needed  
☐ MODIFIED DUTY Please complete the section below.

If restrictions are needed, complete only the issues that need modification.

	Not able to do	up to 2 Hours	up to 4 Hours	up to 6 Hours	up to 8 Hours
1. Lift/carry:					
a. Up to 10 lbs.					
b. 11-20 lbs.					
c. 21-40 lbs.					
d. 41-70 lbs.					
2. Push/pull (wheeled containers) up to 2000 lbs. maximum= <u>40 lbs force</u> : NO RESTRICTIONS:					(or complete below)
Weight Limit _____					
3. Employee can use arms/hands for REPETITIVE:					
a. Reach above shoulder					
b. Simple grasp					
c. Fine manipulation (may include keyboarding)					
4. Employee can perform and/or be exposed to:					
a. Sit					
b. Stand					
c. Walk					
d. Climb					
e. Bend/Stoop					
f. Kneel					
g. Dust					
h. Work Around Machinery					
5. Maintenance Crafts Employee can use or be exposed to:					
a. High Impact vibration (e.g. riveting)					
b. Low Impact vibration (e.g. sanding, drilling)					
c. Chemicals/Solvents					
d. Fumes					
e. Work at Heights					
6. DRIVING (Postal Vehicles)					
7. OVERTIME No Limit _____					

OR: Specify TOTAL work hours/day and days/week \_\_\_\_\_

OTHER RESTRICTIONS \_\_\_\_\_

Check One ☒

- ☒ PERMANENT (yearly renewal is required)
- ☐ TEMPORARY No follow up is needed. FULL DUTY EFFECTIVE \_\_\_\_\_
- ☐ TEMPORARY \*Re-evaluation is needed on or before \_\_\_\_\_

(\*If re-evaluation date is not provided, restrictions are valid for a maximum of one month and an update will be required.)

**Andrew Selby, PA-C**

NAME and ADDRESS of Health Care Provider (printed)

Phone RIVERTON FAMILY MEDICINE

13030 Military Rd S #210

Fax Tukwila, WA 98168

34301 - 9TH AVENUE SOUTH

FEDERAL WAY WA 98003-7090

53-214-1720, x1721 PHONE

53-214-1820 24-HR, CONFIDENTIAL FAX

Signature [Signature]

Date 8/28/13

Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)U.S. Department of Labor  
Wage and Hour DivisionOMB Control Number: 1235-0003  
Expires: 2/28/2015**INSTRUCTIONS to the EMPLOYER:**

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protection due to a serious health condition to submit a medical certification issued by the health care provider before giving you may not ask for more information. Your response to this form to your employee. Your response to the employee to provide more information. Employers must generally maintain records of medical histories of employees created for the purpose of the FMLA Act applies.

03272132

LANCE P MCDERMOTT

110000501305

I before giving  
ou may not ask  
5.306-825.308.  
ations, or  
: files/records  
1 DisabilitiesEmployer name and contact: FMLA SPECIALIST@651-456-6071 Option 5 Fax 651-456-6071Employee's job title: MPE 9 Regular work schedule: Sun - ThursEmployee's essential job functions: MaintenanceCheck if job description is attached: ☐**INSTRUCTIONS to the EMPLOYEE:**

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: LANCE P MCDERMOTT EIN: 03272132  
First Middle Last**INSTRUCTIONS to the HEALTH CARE PROVIDER:**

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: RIVERTON FAMILY MEDICINE  
13030 Military Rd S #210  
Tukwila, WA 98168  
Tel: 206-242-6500 Fax: 206-246-7946Type of practice / Medical specialty: Family PracticeTelephone: ( ) Fax: ( ) Andrew Selby, P.

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**PART A - MEDICAL FACTS**

1. Approximate date condition commenced:

Color blindness, since birth

hypertension / 2 yrs  
anxiety

Probable duration of condition:

lifetime

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☒ No ☐ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

3/29/13, 4/10/13, 6/13/13, 8/14/13

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☒ Yes.Was medication, other than over-the-counter medication, prescribed? ☐ No ☒ Yes.Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
☐ No ☒ Yes. If so, state the nature of such treatments and expected duration of treatment:

Psychologist Dr. Senterman for anxiety

2. Is the medical condition pregnancy? ☒ No ☐ Yes. If so, expected delivery date:

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ No ☒ Yes.

If so, identify the job functions the employee is unable to perform:

working on colored electrical wiring - employer restriction  
[not medical restriction]

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Hostile work environment leading to anxiety  
which contributed to his hypertension  
This is now well controlled with medication  
and decreased anxiety.

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[REDACTED]

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☒ No ☐ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☒ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
☐ No ☒ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Twice yearly

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☒ No ☐ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
☐ No ☐ Yes. If so, explain:

\_\_\_\_\_  
\_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode


[REDACTED]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7

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CONFIDENTIAL


  
Signature of Health Care Provider

8/14/13  
Date
**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**





## Medical Examination &amp; Assessment

AW of IC  
on DTE Oct 96 No 05A

## Privacy Act Statement

The collection of this information is authorized by 39 USC 401 and 1001. This information will be used to provide employees with necessary health care and to determine fitness-for-duty. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes, where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private-relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the

Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1613; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to the Office of Personnel Management in making determinations related to veterans preference, disability retirement and benefit entitlement; to officials of the Office of Workers' Compensation Programs, Retired Military Pay Centers, Veterans Administration, and Social Security Administration in the administration of benefit programs; to an employee's private treating physician and to medical personnel retained by the USPS to provide medical services in connection with an employee's health or physical condition related to employment; and to the Occupational Safety and Health Administration and the National Institute of Occupational Safety and Health when needed by that organization to perform its duties under 29 CFR Part 19. Completion of this form is voluntary. If this information is not provided, the examination may be considered incomplete.

## A: Completed by Examinee (Type or Print in Ink)

1. Name (Last, First, Middle) <u>McBerron, Lance Patrick</u>	2. Social Security Number <u>538 66 99 27</u>	3. Sex <u>M</u>	4. Date of Birth <u>4/15/59</u>
5. Do you have any medical disorder or physical impairment which could interfere in any way with the full performance of duties of the position for which you are applying? (If your answer is "Yes", explain fully to the physician performing the examination).  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		I certify that all the information to be given by me in connection with this examination will be correct to the best of my knowledge and belief.	
		6. Signature <u>Lance Patrick McBerron</u>	7. Date <u>10-24-96</u>

## B: Completed by Appointing/Referring Official Before Examination

1. Exam Type a. <input checked="" type="checkbox"/> Preemployment b. <input type="checkbox"/> Fitness-for-Duty	2. Exam Date <u>10/24/96</u> Location <u>Office</u> Appointment <u>Office</u>	3. Position Applied for or Now Holds a. Title <u>X Cas</u> b. Installation <u>See</u>
c. Reason for Request (complete only if you checked "Fitness-for-Duty")  <input type="checkbox"/> Inadequate Medical Information <input type="checkbox"/> Excessive Absenteeism for Medically Documented Conditions <input type="checkbox"/> Behavioral Problem (Performance, Attitude) <input type="checkbox"/> Other (Specify):		
4. Circle the number preceding each functional requirement and each environment factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, attach the specific medical standards for the information of the examining physician.		

## Functional Requirements

1. Heavy lifting, up to 70 pounds	16. Kneeling ( hours)	26. Far vision correctable in one eye to 20/40 and to 20/100 in the other
2. Moderate lifting, 15-44 pounds	17. Repeated bending ( hours)	27. Specific visual requirement (specify)
3. Light lifting, under 15 pounds	18. Climbing, legs only ( hours)	28. Both eyes required
4. Heavy carrying, 45 pounds and over	19. Climbing, use of legs and arms	29. Depth perception
5. Moderate carrying, 15-44 pounds	20. Both legs required	30. Ability to distinguish basic colors
6. Light carrying, under 15 pounds	21. Operation of crane, truck, tractor, or motor vehicle	31. Ability to distinguish shades of colors
7. Straight pulling ( hours)	22. Ability for rapid mental and muscular coordination simultaneously	32. Hearing (aid permitted) (hear conversational voice 15 feet — one ear)
8. Pulling hand over hand ( hours)	23. Ability to use firearms	33. Hearing without aid
9. Pushing ( hours)	24. Near vision correctable at 13" to 16" to Jaeger 1 to 4	34. Specific hearing requirements (specify)
10. Reaching above shoulder	25. Far vision correctable in one eye to 20/20 and to 20/40 in the other	35. Other (specify)
11. Use of fingers		
12. Both hands required or compensated by the use of acceptable prostheses		
13. Walking ( hours)		
14. Standing ( hours)		
15. Crawling ( hours)		

## Environmental Factors

1. Outside	12. Solvents (degreasing agents)	21. Unusual fatigue factors (specify)
2. Outside and inside	13. Grease and oils	22. Working with hands in water
3. Excessive heat	14. Radiant energy	23. Explosives
4. Excessive cold	15. Electrical energy	24. Vibration
5. Excessive humidity	16. Slippery or uneven walking surfaces	25. Working closely with others
6. Excessive dampness or chilling	17. Working around machinery with moving parts	26. Working alone
7. Dry atmospheric conditions	18. Working around moving objects or vehicles	27. Protracted or irregular hours of work
8. Excessive noise, intermittent	19. Working on ladders or scaffolding	28. Other (specify)
9. Constant noise	20. Working below ground	
10. Dust		
11. Fumes, smoke, or gases		

Lance P. McInerney

SSN

53B

7727

## C: Medical History

(Completed by Examinee Before Examination)

This section contains questions regarding your medical history and health habits. This information will be used to make a medical assessment of whether you can safely and efficiently perform the duties of the position that you now hold or for which you have applied. Detailed medical information will be handled in a confidential manner. Only information that is directly relevant to determining

your ability to function effectively in your work with the Postal Service will be released to the hiring official. It is essential that you answer all questions truthfully and completely. A history of any health problem will not necessarily disqualify you from employment. False or incomplete responses could result in an incomplete examination, or termination if hired.

1. Have you ever been refused employment or been unable to hold a job because of:	Yes	No	8. Have you ever received compensation or a cash settlement from an employer, insurance company, government or other organization for injury or disease? (If "Yes" explain)	Yes	No
a. Sensitivity to chemicals, dust, pollen, sunlight, etc.		X			
b. Inability to perform certain motions		X			
c. Inability to assume certain positions		X			
d. Other Medical Reasons		X	9. Is there a case pending?		X
2. Have you ever required special or restricted job assignment due to illness, injury, or physical impairments? (If "Yes", list accommodations provided).		X	10. Have you ever had an X-ray or other special examination (e.g., electrocardiogram, CAT scan)? (If "Yes" give date and explain).		X
3. Have you ever had or have you, at any time, been treated for a psychiatric disorder? (If "Yes", specify date and give details).		X	11. Have you served in the military?	X	
			12. Have you ever been rejected for or discharged from military service because of any physical or mental reasons? (If "Yes" give date and reasons).		X
4. Have you ever been treated for any medical condition other than minor illness, or had any operations?			13. Have you ever lived or been employed overseas? (If "Yes" state when and number of months. Include military service.)		
5. Have you worked for any length of time involving the handling of chemical, toxic, or dangerous materials?		X	Saudi Arabia Jan 91 - Jul 91		
6. Have you had any known exposure to asbestos or asbestos-related products? (If "Yes" state where and when).		X	14. Have you ever filed a disability claim or received payment or compensation from the US government? (If "Yes", complete a, b, & c below).	X	
7. Have you ever worked in a noisy environment? (If "Yes" state where and when).	X		14a. Your Claim Number		
			14b. Percent Rating		
			14c. Cause:		

VARICO COFLF  
Yavacosis operation 1980

US Army

Lance P. Mc D *mett*

538 6 9927

## C: Medical History (Continued)

(Completed by Examinee Before Examination)

15. Do you exercise regularly? (If "Yes" describe type, amount, and frequency). <i>Bike Basketball</i>	Yes	No	18. Have you ever used any of the following drugs or controlled substances? a. Morphine, Heroin, Methadone, Codeine, Percocet, Percodan, or other narcotic drugs? b. Amphetamines, Methamphetamine, Diet Pills, Cocaine, or other stimulant drugs? c. Barbiturates, Quaaludes, Dalmane, Seconal, or other sedative or hypnotic drugs? d. Marijuana, Hashish, Mescaline, LSD, PCP (angel dust), or other hallucinogenic drugs? e. Librium, Valium, Elavil, or other tranquilizers or antidepressant drugs? f. Are you taking any other prescribed medicines? (If "Yes" give dates and explain.)	Yes	No
16. Have you ever used tobacco? (If "Yes" describe type, amount, age started and age stopped if discontinued). <i>light cigar/pipe</i>			19. If you answered "Yes" to any question in Item 18, answer the following questions: a. Have you ever been dependent upon, or habitually used, any of the drugs or categories of controlled substances listed in Item 18? b. Have you ever been hospitalized or received treatment for use of drugs or other controlled substances? c. Have you ever received treatment for any physical or emotional condition caused by, or related to, your use of drugs or other controlled substances? d. Has your use of drugs or other controlled substances ever affected your work performance, ability to obtain or hold a job or driving privileges, or resulted in arrests or court actions?		
17. Have you ever used alcoholic beverages? (If "Yes" answer the following questions). a. Have you ever been dependent upon, or habitually used, alcoholic beverages? b. Have you ever received treatment for, or participated in any program for alcoholism or drinking problems? c. Has your use of alcoholic beverages ever affected your work performance, ability to obtain or hold a job or driving privileges, or resulted in arrests or court actions?			20. Have you ever failed a "Drug Screen" for any reason? (If "Yes" give date and explain.)		

## 21. Do You Now or Have You Ever Had Any of the Following Conditions? (Give Dates)

	Yes	No		Yes	No
1. Frequent or Severe Headaches		X	33. Venereal Disease (Syphilis or Gonorrhea)		X
2. Disturbance of Vision		X	34. Hemorrhoids or Rectal Disease		X
3. Wear Glasses or Contact Lenses	X		35. Arthritis (Rheumatism or Bursitis)		X
4. Eye Injuries or Abnormalities		X	36. Leg Cramps		X
5. Loss of Hearing		X	37. Painful or Swollen Joint		X
6. Ear Abnormalities		X	38. Foot Trouble - Flat Feet		X
7. Chronic Sinus Trouble		X	39. Bone Fracture		X
8. Hoarseness		X	40. Limb Disorders		X
9. Goiter or Thyroid Trouble		X	41. Amputation (Where?)		X
10. Enlarged Glands in Neck or Other Area		X	42. Back Surgery		X
11. Stiffness of Neck		X	43. Back Injury or Abnormality		X
12. Chronic Cough (Check if Blood is Present <input type="checkbox"/> )		X	44. Paralysis		X
13. Frequent Colds		X	45. Cancerous Tumor or Cyst		X
14. Wheezing or Asthma		X	46. Numbness, Weakness, Tremors, or Dizziness		X
15. Lung Disease		X	47. Skin Condition (e.g., Eczema, Hives, Fungus or Rash)		X
16. Pain or Pressure in Chest		X	48. Allergies	X	
17. Shortness of Breath		X	49. Pilonidal or Other Cysts		X
18. Heart Abnormality		X	50. Discoloration, Birthmarks, Scars		X
19. Heart Attack (When?)		X	51. Diabetes		X
20. Heart Murmur		X	52. Gout		X
21. High Blood Pressure		X	53. Stroke		X
22. Unexplained Weight Change		X	54. Epilepsy, Seizures, or Blackouts		X
23. Digestive Abnormality		X	55. Rheumatic Fever		X
24. Recurring Abdominal Pain		X	56. Tuberculosis		X
25. Frequent Diarrhea (Check if blood is present <input type="checkbox"/> )		X	57. Hepatitis		X
26. Frequent Constipation		X	58. For Females: Female Disorders		
27. Jaundice Disease		X	59. For Females: Are You Pregnant?		
28. Kidney or Bladder Disease		X	60. For Males: Abnormalities of Genitals <i>Venereal Virus</i>		X
29. Kidney or Bladder Stones		X	61. Have You Ever Had Any Illness/Injury Other Than Those Listed Above?		
30. Bloody Urine		X			
31. Trouble Passing Urine (Pain or Frequency)		X			
32. Hernia		X			

## D: Medical Findings (For Preemployment and Fitness-for-Duty Exams)

(Completed by Examining Physician)

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine is being considered for a position (or, if a Fitness-for-Duty exam, has a position) which will include the functional requirements and environmental factors circled in Section B., Item 4. In conducting your examination and reporting your findings and conclusions, take these factors into consideration.

1. Examinee's Name Lance McDermott 2. SSN 538 66 9927 3. Height (Feet, Inches) 5'9" 4. Weight (Pounds) 180

## 5. Eyes

	Snellen (Distant Vision)	Jaeger (Near Vision)
Without Glasses	a. Right 20 _____ Left 20 _____	b. Right <u>11</u> in. to <u>14</u> in., Left <u>11</u> in. to <u>14</u> in.
With Glasses	c. Right 20 <u>20</u> Left 20 <u>20</u>	d. Right _____ in. to _____ in., Left _____ in. to _____ in.
e. Is color vision normal when Ishihara or other color plate test is used? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		f. If the answer is "No", can applicant pass lantern or other compatible? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

## 6. Ears

a. Ordinary Conversation  
Right ear @ 15 ft. OK Left ear @ 15 ft. OK b. Audiometer (Attach Audiogram if indicated)

## 7. Blood Pressure/Pulse

a. Systolic/Diastolic 118/76 b. Two Additional Readings if Elevated \_\_\_\_\_ c. Pulse 76

## 8. Urinalysis

a. Albumin (Multi-Test Stick) 3+ b. Sugar (Multi-Test Stick) POS - 117 c. Blood (Multi-Test Stick) 3+ d. Drugs Identified if Test Indicated \_\_\_\_\_

## 9. Physical Examination

NOTE: Routine pelvic examinations are not done by postal medical officers or contract physicians

Clinical Evaluation	Normal	Ab-normal	Clinical Evaluation	Normal	Ab-normal
a. Head, face, neck, and scalp	✓		l. Anus and rectum (If indicated)	✓	
b. Nose	✓		m. Endocrine system	✓	
c. Mouth and throat	✓		n. Hernia (Any type)	✓	
d. Ears	✓		o. Upper extremities	✓	
e. Eyes	✓		p. Feet	✓	
f. Ophthalmoscopic	✓		q. Lower extremities	✓	
g. Ocular motility	✓		r. Spine	✓	
h. Lungs and Chest (Breasts, if indicated)	✓		s. Identifying body marks, scars	✓	
i. Heart	✓		t. Skin, lymphatics	✓	
j. Vascular system (Varicosities, etc.)	✓		u. Neurologic	✓	
k. Abdomen	✓		v. Mental status	✓	



Examinee's Name

Lance Mc Dermott

SSN

538 66 99 27

## 10: Summary of Medical Findings

(Explain in detail any abnormality noted in history or physical examination)

Generally healthy - post op  
 was recovered No post op  
 of glycosuria which is probably  
 benign. No mus-skel weakness  
 OK constitution

9a. Physician's Name (Type or Print)

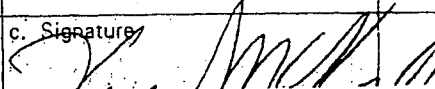
- ☐ Medical Officer  
☐ Contract Physician  
☐ Private Physician

KEVIN M. O'NEFF, M.D.

b. Address (Include ZIP + 4)

OCCUPATIONAL HEALTH RESOURCES  
 2203 AIRPORT WAY S STE 100  
 SEATTLE WA 98148

c. Signature



d. Date

OCT 24 1996

IMPORTANT - Examining Physician: If you are not a Postal Medical Officer, sign and return the entire form, intact, in the preaddressed Restricted/Medical envelope within 5 days of the

NOTE: Insert Carbon from page 1 between parts 1 &amp; 2 of this page before completing.

E. Medical Assessment by Postal Medical Officer, Contract Physician

Examinee's Name (Last, First, MI)

SSN

Complete All Items Below in Lay Terms  
to Observe Privacy Considerations

McDermott, Lance P

538 66 9927

1. Medical History: Based upon review of Section C of this form, Examinee's Medical History, VA records (if applicable), outside medical records, etc., check appropriate box below. Note any significant past medical data that is pertinent to the physical, and medical data that is pertinent to the physical and mental requirements of the essential functions of the position applied for.

☒ No Significant Finding

☐ Significant Findings as Noted:  
(Observe privacy considerations)

2. Physical Findings: Based upon a complete physical examination and mental status examination (if indicated), check appropriate box below.

☒ No Limitations/Restrictions

☐ Limitations/Restrictions as Noted:

☐ Specialist Exam Required with Narrative Report  
Note any restrictions (inabilities) and/or limitations (partial disabilities) identified.

Do not complete Item 4, below, until specialist's report is reviewed.)

3. Employment History: Based upon review of examinee's PS Form 2591; Application for Employment (if applicable), Supervisor's Evaluations, prior job descriptions, etc., check appropriate box below. Note any employment data that is pertinent to past or current medical conditions. Note only that employment data which supports the examinee's ability to perform the essential functions of the position for which the examinee has applied.

☒ No Significant Findings

☐ Significant Findings as Noted:

4. Risk Assessment: NOTE: Do not complete this section until specialist's report (if required) has been reviewed.

*Essential Functions* Based upon a review of findings as noted in nos. 1-3; above, indicate assessment of applicant's risk of incurring job-related injury or illness, within the next six months, due to existing or past medical conditions.

☒ No Medical Risk/Restriction: Examinee is medically qualified to perform essential functions of the position without accommodation.

☐ Moderate Risk/Restriction: Examinee would be medically qualified to perform essential function of the position only if below noted limitations/restrictions can be accommodated. (See No. 5 below.)

☐ Low Risk/Restriction: Examinee is medically qualified to perform essential functions of the position at the time of examination, but periodic medical follow-up is recommended. (See No. 5, below.)

☐ High Risk/Restriction: Examinee is not medically qualified to perform essential functions of the position. Accommodations will not reduce medical risk or restriction.

5. Suggested Accommodations: (Job modifications which would allow examinee to perform essential functions of the position effectively and safely)

None - OS

Signature of Medical Authority

Date

Name

 OCCUPATIONAL HEALTH SERVICES  
 2203 AIRPORT WAY S. STE. 200  
 SEATTLE, WA 98134

OCT 24 1996

F. Completed by Appointing/Referring Official (HBK-EL 311,343.5)

Enter Action Taken

Name &amp; Location (Type or Print)

☐ Selected for Appointment

☐ Fit for Duty

☐ Not Selected for Appointment

☐ Not Fit for Duty

Signature

Date